VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

August 8, 2019

Ms. Jeana Lavallee, Manager
Living Well Residence
71 Maple Street
Bristol, VT 05443-1004

Dear Ms. Lavallee:

Enclosed is a copy of your acceptable plans of correction for the investigation survey conducted on **July 16, 2019.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

PRINTED: 07/19/2019
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0543	A. BUILDING: _____ B. WING _____	C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL RESIDENCE	71 MAPLE STREET BRISTOL, VT 05443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An on-site anonymous complaint investigation was conducted by the Division of Licensing and Protection on 7/15 and 7/16/19. There were regulatory findings.	R100		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to insure that medication administration was consistent with the physician's orders for 1 of 2 residents, Resident #1. Findings include: Resident #1 was accompanied to the physician by the facility's Registered Nurse (RN) on 6/24/19 and an order for Levaquin 500 mg by mouth daily (milligrams) was given to the nurse, secondary to Resident #1 being diagnosed with pneumonia and refusing hospitalization at the time. During an interview with the RN, s/he stated that the Levaquin was to be started as soon as possible. S/he further stated that the prescription was faxed to the pharmacy and spoke with the medication technician (med tech) that was on duty and left notification for the evening staff. Per interview with the house manager, the med tech that was on duty signed for the Levaquin, but did not administer it. The med tech stated that s/he was aware of the order because of the notification	R128	R128: Beginning 07/19/19 House Manager, RN, and all med techs began using the built in message system available through QuickMar (electronic MAR). All new orders will be communicated by the nurse or House Manager via message through this system. Any messge containing information or instructions about new orders or med changes will require a response to the sender aknowledging receipt of the message within 10 minutes after the start of any employees next scheduled shift. This is how we will ensure that all med techs are aware of new orders and special instructions. This system also provides immediate monitoring for success in that, the nurse will know if she has not received a response from the med tech within the stated timeframe. She will then follow up with a phone call. The (cont)	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: House Manager — (X6) DATE: 8/2/19

R128 - R161 POC accepted 8/5/19 BBottelRN/PMR

PRINTED: 07/19/2019
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0543	A. BUILDING: _____ B. WING _____	C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL RESIDENCE	71 MAPLE STREET BRISTOL, VT 05443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R128	Continued From page 1 from the RN, but did not question why it was crossed out on the electronic MAR. The house manager confirmed at 3:55 PM on 7/16/19 that the med tech should have administered the medication per order and that education needed to be provided to the med tech regarding following physician orders.	R128	Nurse provided additional one on one education to the Med Tech on 7/19/19 and 7/26/19 regarding both receiving meds from the pharmacy and physician orders. As of 07/19/19 all Med Techs were instructed to call Nurse or House Manager for clarification in the event that any order appears greyed out, which is indicative of an error. Discontinued orders appear with a yellow flag.	
R155 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c. (12) Assume responsibility for staff performance in the administration of or assistance with resident medication in accordance with the home's policies. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Nurse failed to insure that staff performed the administration of medication in accordance with the home's policies for 1 of 3 residents, Resident #1. Findings include: Resident #1 was accompanied to the physician by the facility's Registered Nurse (RN) on 6/24/19 and an order for Levaquin 500 mg by mouth daily (milligrams) was given to the nurse, secondary to Resident #1 being diagnoses with pneumonia. During an interview with the RN, s/he stated that the physician wanted the resident to be hospitalized, but due to resident refusal Levaquin was to be started as soon as possible. The evening medication tech confirmed on 7/16/19 that s/he did not give the medication and did not question why it was ordered but was grayed out on the Medication Administration Record, which	R155	R155: Beginning 07/19/19 the House Manager, RN, and all Med Techs began using the built in message system available through QuickMar (electronic MAR). All new orders will be communicated by the Nurse or House Manager via message through this system. Any message containing information or instructions about new orders or med changes will require a response to the sender aknowledging receipt of the message within ten minutes after the start of any employees next scheduled shift. This is how we will ensure that all med techs are aware of new orders or special instructions.This system also provides immediate monitoring for success in that, the nurse will know that she has not received a response from the med tech within the stated timeframe. She will then follow up with a phone call. The Nurse provided additional one on one education to the Med Tech on 7/19/19 and 7/26/19	

PRINTED: 07/19/2019
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0543	A. BUILDING: _____ B. WING _____	C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL RESIDENCE	71 MAPLE STREET BRISTOL, VT 05443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R155	Continued From page 2 indicates that it was discontinued. The Registered Nurse stated that it was the expectation that the medication be given per the orders of the physician. The house manager stated on 7/16/19 at 3:55 PM that the med tech would need to be re-trained about the policies of medication administration per the physician orders.	R155	regarding both receiving meds from the pharmacy and physician orders. As of 07/19/19 all Med Techs were instructed to call Nurse or House Manager for clarification in the event that any order appears greyed out,which is indicative of an error. Discontinued orders appear with a yellow flag.	
R161 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Manager failed to insure that medications were handled according to home policies for one of three residents, Resident #1. Findings include: Resident #1 was accompanied to the physician by the facility's Registered Nurse (RN) on 6/24/19 and an order for Levaquin 500 mg by mouth daily (milligrams) was given to the nurse, secondary to the resident having a diagnosis of pneumonia and refusal to being admitted to the hospital at this time. During an interview with the RN, s/he stated that the Levaquin was to be started as soon as possible. The evening medication tech confirmed on 7/16/19 that s/he did not give the medication and did not question why it was ordered but was grayed out on the Medication	R161	R161: Beginning 7/19/19 the House Manager, RN, and all Med Techs began using the built in message system available through QuickMar (electronic MAR). All new orders will be communicated by the Nurse or House Manager via message through this system. Any message containing information or instructions about new orders or med changes will require a response to the sender aknowledging receipt of the message within ten minutes after the start of any employees next scheduled shift. This is how we will ensure that all Med Techs are aware of new orders or special instructions. This system also provides immediate monitoring for success in that, the nurse will know if she has not received a response from the Med Tech within the stated timeframe. She will then follow up with a phone call. The Nurse provided additional one on one education to the Med Tech on 7/19/19 and 7/26/19 regarding receiving meds from the pharmacy and physician orders. As of 7/19/19 all Med Techs were instructed to call Nurse or House Manager for clarification in the event that any order appears greyed out, which is indicative of an error. Discontinued orders appear with a yellow flag.	

PRINTED: 07/19/2019
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0543	A. BUILDING: _____ B. WING _____	C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL RESIDENCE	71 MAPLE STREET BRISTOL, VT 05443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R161	Continued From page 3 Administration Record, which indicates that it was discontinued. The Registered Nurse stated that it was the expectation that the medication be given per the orders of the physician. The house manager stated on 7/16/19 at 3:55 PM that the med tech would need to be re-trained about the policies of medication administration per the physician orders. The house manager was unaware of the medication not being administered until being alerted by a nurse at the hospital that stated it was listed on the medication list, but that it did not appear to have been administered.	R161	Attached please find letter of clarification from Nurse.	

Points of Clarification

7/30/19

The surveyor called me on my cell phone and it was not a clear connection. I was at another place of work and could not hear well. To clarify, the physician did not say "as soon as possible" nor was this written on the order. The Nurse told the pharmacy to deliver the med as soon as possible.

To clarify the statement that the resident refused hospital care, she did not refuse. She was offered the choice of treatment in the hospital or at home. She chose to be treated in her home (Living Well Residence).

The Nurse and House Manager will schedule a meeting with Wilcox pharmacy to again discuss this specific issue and how errored orders can be prevented or communicated.

Thank you,

Dorothy Delaney RN

Living Well Residence